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William M. Stelwagon

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NOTE

DOES A HEALTHY PATIENT NEED A CURE? A RESPONSE TO HEALTH CARE INDUSTRY PROPOSALS TO REFORM ANTITRUST ANALYSIS OF HORIZONTAL HOSPITAL MERGERS

INTRODUCTION

The past ten years have witnessed a significant number of horizontal mergers¹ and other collaborative activity² in the health care industry.³

¹ "A horizontal merger is defined as a merger between firms engaged in similar lines of production." Brian Golden, Note, *The Evolution of Horizontal Mergers and the 1992 Merger Guidelines*, 28 NEW ENG. L. REV. 159, 159 n.4 (1993) (citations omitted).

² Collaborative activities include acquisitions and joint ventures. Frederic J. Entin et al., *Hospital Collaboration: The Need for an Appropriate Antitrust Policy*, 29 WAKE FOREST L. REV. 107, 114 (1994).

³ See Brian J. McCarthy & Toni Weinstein, *Special Strategies Sidestep Legal, Regulatory Obstacles To Health Care Mergers and Acquisitions*, 11 NO. 4 HEALTHSPAN 7, 7 (1994) (describing mergers as "rampant among all segments of the health care industry"). The American Hospital Association has advocated health care collaborations "to improve access and quality [of health care services] and to reduce the precipitous rise of health care costs." Entin et al., *supra* note 2, at 109; see Sandy Lutz, *Let's Make a Deal: Healthcare Mergers, Acquisitions Take Place at Dizzying Pace*, MOD. HEALTHCARE, Dec. 19, 1994, at 47 ("More than 650 of the nation's hospitals were involved in mergers or acquisitions in 1994, eclipsing the number of hospital deals in recent years."); Erik Eckholm, *Healing Process: A Special Report; While Congress Remains Silent, Health Care Transforms Itself*, N.Y. TIMES, Dec. 18, 1994, at A1 (highlighting effectiveness of health care industry's actions to reduce costs and increase efficiency in face of Congressional inaction on reform); Milt Freudenheim, *Market Place; There May Be More Hospital Mergers Before the Dust Clears*, N.Y. TIMES, Oct. 14, 1994, at D6 [hereinafter *Before the Dust Clears*] (discussing recent mergers between National Medical Enterprises and American Medical Holdings, and between Columbia/HCA Healthcare and Healthtrust); see also Joy Greene & Sandy Lutz, *Systems Post 4th Straight Year of Income Growth*, MOD. HEALTHCARE, May 23,

Large proprietary hospital corporations are merging⁴ and acquiring nonprofit hospitals with increasing frequency.⁵ Several factors operate in combination to encourage collaboration: (1) overcapacity resulting from increased competition with managed care organizations; (2) technological advances in health services; and (3) the desire of hospitals to reduce dependency on federal funding and create additional sources of capital.⁶ In addition, the trend toward hospital combination has been attributed to the shift in federal spending policy from support of hospital expansion to control of health care costs.⁷

1994, at 36 (discussing 1993 as year of "merger mania" for hospitals); *1994 Mergers and Acquisitions*, MOD. HEALTHCARE, Dec. 19, 1994, at 48 (listing hospital mergers in United States during 1994).

⁴ See, e.g., *Before the Dust Clears*, *supra* note 3, at D6 (discussing possible merger between two largest proprietary hospital chains); *Texas, Two Other AGS to Mull Columbia/HCA-Healthtrust Merger*, HOUS. POST, Oct. 25, 1994, at C6 (describing review of major proprietary hospital mergers by state attorneys general); Sallie Hofmeister, *A \$3.3 Billion Hospital Deal Is Proposed*, N.Y. TIMES, Oct. 12, 1994, at D1 (discussing major proprietary hospital mergers). Of the approximately 5369 general acute-care hospitals in the United States in 1993, private investors owned approximately 13.3%. NATIONAL MEDICAL ENTERPRISES, PRELIMINARY PROSPECTUS, \$100,000,000 NOTE OFFERING 56 (1995) [hereinafter NATIONAL MEDICAL ENTERPRISES].

⁵ See, e.g., Milt Freudenheim, *Hospitals Are Tempted but Wary as For-Profit Chains Woo Them*, N.Y. TIMES, Jan. 4, 1995, at A1 ("[Nonprofit hospitals] are eager to preserve their identity and protect their mission. But they are also aware that to survive at all, they may have to merge with other hospitals."); see also Sandy Lutz, *Not-For-Profit Keeps Clout in N.D. Deal*, MOD. HEALTHCARE, Jan. 9, 1995, at 8 (describing merger between for-profit Champion Healthcare Corp.'s Heartland Medical Center and nonprofit Dakota Hospital); Thom Wilder, *Catholic Hospitals Brace for Mergers: Cleveland Deal Being Watched Closely*, 3 Health Care Pol'y Rep. (BNA) No. 45 (Oct. 9, 1995) (reporting first merger between nonprofit Catholic hospital and investor-owned chain and discussing concerns of nonprofit community regarding merger).

⁶ See Stephen W. Bernstein, *Hospital Mergers, Acquisitions and Affiliations: The Anatomy of Motivations, Models, Process and Legal Considerations*, in HEALTH CARE LAW 1993, at 77, 77-78 (PLI Com. L. & Practice Course Handbook Series No. A4-4428, 1993). Bernstein presents additional factors which may explain the trend toward collaboration, *id.*, including preparation for federal health care reform lower occupancy levels due to technological advances, the desire to reduce duplicate services, and the desire to promote community well-being. *Id.*; see also Thomas M. Susman & David A. Martland, *The Brave New World of Health Care: Hospital Mergers and Joint Ventures in the 90s*, 38 BOSTON B.J. 3, 3 (1994) (attributing hospital collaboration to "[o]vercapacity, downward pressures on prices, the desire of large buyers to obtain a full array of health care services from a single provider, and the specter of significant health care reform legislation"). One commentator has argued that the hospital industry is a "natural monopoly . . . where the cost at which a single firm can produce a given product or service to satisfy the entire market demand is less than the cost at which several competing firms can produce the same product or service." Dayna B. Matthew, *Doing What Comes Naturally: Antitrust Law and Hospital Mergers*, 31 HOUS. L. REV. 813, 820 (1994).

⁷ See Entin et al., *supra* note 2, at 108-09. Federal legislation has had a strong impact on the development of hospital markets in the United States. *Id.* at 139. The Lanham Act, Pub. L. No.

This trend toward hospital collaboration has generated significant criticism of antitrust policy in the hospital industry.⁸ Part I of this Note will examine current antitrust law concerning horizontal hospital mergers, with particular emphasis on the analysis used by the Federal Trade Commission ("FTC") and the Department of Justice Antitrust Division ("DOJ"). Part II of this Note will examine hospital industry criticism of current antitrust law, and the federal enforcement agencies' response to this criticism. Finally, Part III of this Note will argue that current antitrust law, as enforced by the FTC and the DOJ, is both necessary and sufficiently flexible to encourage pro-competitive collaboration among hospitals.

I. ANALYSIS UNDER SECTION SEVEN OF THE CLAYTON ACT

Section Seven of the Clayton Antitrust Act⁹ ("Section Seven") prohibits horizontal mergers that "substantially . . . lessen competition, or

77-137, §§ 202-03, 55 Stat. 361, 362-63 (1941), and the Hospital Survey and Construction Act of 1946, Pub. L. No. 79-725, ch. 958, 60 Stat. 1040 (codified as amended in scattered sections of 24 U.S.C., 31 U.S.C., 33 U.S.C., 42 U.S.C., 46 U.S.C., 48 U.S.C., and 49 U.S.C.), both provided federal funding for hospital construction. Entin et al., *supra* note 2, at 139. Moreover, Medicare and Medicaid sharply increased the amount of hospital spending financed with federal funds. *Id.* However, "[t]he Social Security Amendments of 1983, which implemented the prospective payment system (PPS) for inpatient hospital services, radically changed the operation of hospitals by replacing the historic cost-based reimbursement with a fixed price system." *Id.* at 142; *see* Social Security Amendments of 1983, Pub. L. No. 98-21, §§ 601-07, 97 Stat. 65 (codified as amended at scattered sections of 26 U.S.C. and 42 U.S.C.). Commentators suggest that these changes in the federal funding system resulted in overcapacity which thereafter provided motivation for hospital collaboration. Entin et al., *supra* note 2, at 142.

⁸ *See infra* notes 91-99 and accompanying text (discussing criticism of antitrust laws); *see also* Matthew, *supra* note 6, at 870 (concluding that current antitrust policy is inappropriate in context of natural monopolies created by hospital markets); Susman & Martland, *supra* note 6, at 3 ("The American Hospital Association and the American Medical Association have argued forcefully that antitrust enforcement is counter-productive and chills potentially cost-saving consolidations."); Entin et al., *supra* note 2, at 137 ("As the dominant player in hospital markets, the federal government has a special responsibility to ensure that the antitrust laws are not used to frustrate community-based efforts to promote beneficial hospital collaboration."); Richard A. Feinstein, *Health Care Mergers: Federal Antitrust Law and Significant Trends*, in HEALTH CARE LAW 1993, at 9 (PLI Com. L. & Practice Course Handbook Series No. A4-4428, 1993) (discussing hospital industry challenges to application of traditional antitrust analysis to hospital mergers). *But see* David L. Meyer & Charles F. Rule, *Health Care Collaboration Does Not Require Substantive Antitrust Reform*, 29 WAKE FOREST L. REV. 169, 189 (1994) (showing that despite current antitrust laws, only eight of 200 mergers since 1987 have been challenged); Department of Justice and Federal Trade Commission Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, 4 Trade Reg. Rep. (CCH) ¶ 13,152, at 20,774 (Sept. 30, 1994) [hereinafter Policy Statements] (indicating that agency challenges to hospital mergers are "relatively rare" and generally conclude within one month).

⁹ Clayton Act, ch. 323, § 7, 38 Stat. 731 (1914) (codified as amended at 15 U.S.C. § 18 (1994)).

... tend to create a monopoly.”¹⁰ To determine if a hospital merger creates this prohibited adverse competitive effect, courts and commentators have looked to the joint merger guidelines¹¹ and the joint statements of antitrust policy concerning the health care industry¹² first published by the DOJ and the FTC in 1992.¹³ These enforcement standards are particularly important given the deference accorded administrative decisions by the courts.¹⁴ Section Seven antitrust analysis requires consideration of the following factors: the relevant product and geographic markets within which the merging hospitals operate; market concentration; competitive impact of the merger; and ownership structure and size of the merging hospitals.

A. *The Relevant Market in Hospital Mergers*

Analysis of mergers under Section Seven begins with defining the relevant market in which the mergers occur.¹⁵ The relevant market

¹⁰ 15 U.S.C. § 18; see *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381, 1386 (7th Cir. 1986) (identifying “ultimate issue” in Section Seven cases as whether challenged merger has potential to “facilitate collusion”), *cert. denied*, 481 U.S. 1038 (1987).

¹¹ Department of Justice Antitrust Division and Federal Trade Commission 1992 Horizontal Merger Guidelines, 57 Fed. Reg. 41,552 (1992) [hereinafter *Merger Guidelines*]. The 1992 Merger Guidelines marked the first joint effort of the FTC and DOJ to clarify enforcement policies concerning Section Seven of the Clayton Act and Section One of the Sherman Antitrust Act. *Id.* The Guidelines were intended to deter mergers which would adversely affect competition, encourage mergers which would increase competition, and enhance the predictability of agency enforcement. *Id.* at 41,553.

¹² See Policy Statements, *supra* note 8, at 20,774. “The Agencies’ analysis of hospital mergers follows the five steps set forth in the Department of Justice/Federal Trade Commission 1992 Horizontal Merger Guidelines.” *Id.*

¹³ The DOJ and FTC have concurrent jurisdiction to enforce the provisions of the Clayton Act. *United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1282 (7th Cir.), *cert. denied*, 498 U.S. 920 (1990).

¹⁴ See *Hospital Corp.*, 807 F.2d at 1385. When the FTC determines under the Clayton Act that a merger should be prohibited because it creates the danger of collusion, the determination will be upheld by federal courts if the FTC’s conclusion is supported by “substantial evidence.” *Id.*; see also *Ukiah Valley Medical Ctr. v. FTC*, 911 F.2d 261, 264 (9th Cir. 1990) (holding that issuance of FTC complaint is not final and reviewable by courts because it does not “impose an obligation, deny a right, or fix some legal relationship as a consummation of the administrative process”) (quoting *Chicago & S. Air Lines, Inc. v. Waterman S.S. Corp.*, 333 U.S. 103, 113 (1948)).

¹⁵ “Determination of the relevant product and geographic markets is ‘a necessary predicate’ to deciding whether a merger contravenes the Clayton Act.” *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602, 618 (1974) (quoting *United States v. E.I. du Pont de Nemours & Co.*, 353 U.S. 586, 593 (1957)). The 1992 Merger Guidelines provide:

A merger is unlikely to create or enhance market power or to facilitate its exercise unless it significantly increases concentration and results in a concentrated market, properly defined and measured. Mergers that either do not significantly increase

includes a product or group of products sold by the merging entities and the geographic area within which the products are sold.¹⁶

1. The Relevant Product Market

The product market is defined as the product or group of products for which a price increase by a monopolist would be profitable due to consumer unwillingness or inability to purchase alternative products.¹⁷

concentration or do not result in a concentrated market ordinarily require no further analysis. . . . Accordingly, for each product or service . . . of each merger firm, the Agency seeks to define a market in which firms could effectively exercise market power if they were able to coordinate their actions.

Merger Guidelines, *supra* note 11, at 41,554; see *Rockford*, 898 F.2d at 1284 (acknowledging that key to determining effects of mergers on market concentration is correctly defining market in which merger occurs); Owen S. Mudge, Jr. & Allan Gibofsky, *The Developing Application of Antitrust Laws to Hospital Mergers*, 15 J. LEGAL MED. 355, 360 (1994) ("The first step in evaluating a potential antitrust violation is to define the relevant market."); Susman & Martland, *supra* note 6, at 3 ("The first, and often most important, step in analyzing a merger is to define the relevant product and geographic market."). The relevant product and geographic market in conjunction with a firm's calculated percentage of output in the relevant market are used to determine the firm's market power, or power to control prices or exclude competition. Golden, *supra* note 1, at 160-61. When a small number of suppliers comprise a high percentage of the aggregate market share, it is easy for those suppliers to charge a price above competitive levels without losing business. *Rockford*, 898 F.2d at 1283. In the context of antitrust law, generally, the issue is not the pre-merger market power of the firms involved; rather it is the *potential* market power resulting from the merger. HERBERT HOVENKAMP, *ECONOMICS AND FEDERAL ANTITRUST LAW* 85 (1985). For a general discussion of the manner in which economics should mold antitrust law, compare LAWRENCE A. SULLIVAN, *HANDBOOK OF THE LAW OF ANTITRUST* 1-17 (1977) (advocating, in accordance with populist school theory, that economics should play limited role in antitrust law) with RICHARD A. POSNER, *ANTITRUST LAW: AN ECONOMIC PERSPECTIVE* (1976) (advocating, in accordance with Chicago school theory, that economics play vital role in antitrust law).

¹⁶ The 1992 Merger Guidelines define the relevant market as:

[A] product or group of products and a geographic area in which it is produced or sold such that a hypothetical profit-maximizing firm, not subject to price regulation, that was the only present and future producer or seller of those products in that area likely would impose at least at a "small but significant and non-transitory" increase in price, assuming the terms of sale of all other products are held constant.

Merger Guidelines, *supra* note 11, at 41,554; see *FTC v. University Health, Inc.*, 938 F.2d 1206, 1210-11 (11th Cir. 1991) (defining relevant product and geographic markets for hospital mergers); *Rockford*, 898 F.2d at 1284 (same); Mudge & Gibofsky, *supra* note 15, at 360 ("The relevant market is comprised of the relevant product market and the relevant geographic market . . .").

¹⁷ Merger Guidelines, *supra* note 11, at 41,554. If, however, alternative products are attractive enough to induce consumers to purchase them when the monopolist raises prices or lowers production levels, then the product market is drawn too narrowly. *Id.* at 41,555. If such alternative products exist, the products should be added to the definition of the relevant product market. *Id.*

This product market definition assumes, however, that the monopolist is not engaging in price discrimination. *Id.* Because different buyers may be more or less likely to resort to alterna-

Disagreement exists, however, on whether the relevant product market for hospital mergers is limited to services provided by inpatient acute-care facilities¹⁸ or includes the outpatient facilities with which inpatient acute-care hospitals compete.

The United States Courts of Appeals for the Eleventh and Seventh Circuits advocate the narrow definition.¹⁹ In *FTC v. University Health, Inc.*,²⁰ the FTC sought to enjoin the asset acquisition of one nonprofit hospital by another.²¹ The Eleventh Circuit vacated the Southern District of Georgia's denial of the injunction.²² The circuit court acknowledged the district court's definition of the relevant product market as including only acute-care inpatient facilities, as well as its conclusion that the post

tive products, the monopolist can identify the buyers less likely to resort to alternative products and target price increases toward them. *Id.* Therefore, the relative sensitivity of the product market to price increase must also be considered when defining the market. Merger Guidelines, *supra* note 11, at 41,555.

¹⁸ An acute-care general hospital is characterized by a highly developed infrastructure, extensive service base, sophisticated equipment, and skilled personnel. NATIONAL MEDICAL ENTERPRISES, *supra* note 4. Non-acute care services typically include nursing homes, outpatient clinics, social services and physician offices. See Jay Greene, *Diversification, Take Two: Hospitals Are Adding Non-Acute-Care Services to Broaden Their Marketability and Boost Their Appeal to Healthcare Buyers*, MOD. HEALTHCARE, July 12, 1993, at 28 (including long-term care, physical rehabilitation, ambulatory care, and physician-hospital joint ventures as typical non-acute services). Many large for-profit hospital chains are venturing into the growing sub-acute-care market as a cost efficient alternative to traditional hospital services. See John Burns, *Subacute Care Feeds Need to Diversify; Providers See Growing Market in the Middle Ground of Healthcare*, MOD. HEALTHCARE, Dec. 13, 1993, at 34 ("Subacute units house patients who no longer require inpatient acute-care services yet need a higher level of care than is available in a traditional skilled-nursing facilities or at home.").

¹⁹ See *University Health*, 938 F.2d at 1210-11 (adopting district court product market definition which included *only* inpatient services by acute-care hospitals); *Rockford*, 898 F.2d at 1284 (limiting product market definition to "provision of inpatient services by acute-care hospitals"); *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381, 1388 (7th Cir. 1986) (declining to extend definition of product market to include outpatient services).

²⁰ 938 F.2d 1206 (11th Cir. 1991).

²¹ *Id.* at 1210. Under the proposed merger, University Health was to control 43% of the relevant hospital market in Augusta, Georgia. *Id.* at 1211. Further, the remaining 57% of the market would have been controlled by only three hospitals. *Id.* at 1210-11. In fact, the merger would have taken one hospital out of the general acute-care market, thus leaving only four hospitals serving that market. *Id.* at 1210.

²² *University Health*, 938 F.2d at 1225-26. The court held that the FTC made a strong prima facie showing that the proposed acquisition would substantially reduce competition and that University Health failed to rebut this showing. *Id.* at 1224. The FTC demonstrated that the acquisition would have left the relevant market highly concentrated with a substantial opportunity for hospital collusion to undermine competitive behavior. *Id.* at 1219. Moreover, increased market concentration in conjunction with Georgia's certificate-of-need law, posed a significant threat to competition because there would be little opportunity for other firms to enter the market. *Id.*

merger market would be highly concentrated, but criticized the district court's failure to grant the injunction to the FTC based on this analysis.²³ The Seventh Circuit addressed the definition of "relevant product market" in *Hospital Corporation of America v. FTC*.²⁴ In *Hospital Corp.*, the largest proprietary hospital chain in the United States acquired two other national proprietary hospital chains.²⁵ Before the acquisition, the buyer owned only one hospital in Chattanooga, Tennessee.²⁶ As a result of the acquisition, however, the buyer gained ownership of two additional hospitals in Chattanooga, as well as management contracts for two others.²⁷ The Seventh Circuit affirmed the FTC determination that the merger violated Section Seven of the Clayton Act.²⁸ The court defined the relevant product market narrowly, reasoning that, "although hospitals increasingly are providing services on an out-patient basis, thus competing with nonhospital providers of the same services[,] . . . most [inpatient] hospital services cannot be provided by nonhospital providers."²⁹

²³ *University Health*, 938 F.2d at 1210-11. The Eleventh Circuit based this conclusion on the belief that the proposed merger would allow hospitals in the Augusta market to increase prices or reduce output of services without fear of competition from smaller acute-care providers. *Id.* at 1219.

²⁴ 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987). The Seventh Circuit also addressed this issue in *United States v. Rockford Memorial Corp.*, 898 F.2d 1278 (7th Cir. 1989), *cert. denied*, 498 U.S. 920 (1990).

²⁵ *Hospital Corp.*, 807 F.2d at 1383.

²⁶ *Id.*

²⁷ *Hospital Corp.*, 807 F.2d at 1383-84. Hospital Corporation, therefore, owned or managed five of the eleven hospitals in the relevant area after the acquisition. *Id.* at 1384. Later, Hospital Corporation cancelled one of its newly acquired management contracts. *Id.* The Seventh Circuit concluded that this type of postacquisition transaction need not be considered in determining the effect of a merger on market concentration. *Id.*

²⁸ *Hospital Corp.*, 807 F.2d at 1385. The court reasoned that the FTC provided "substantial evidence" that the acquisition was likely to create adverse competitive effects. *Id.* The Seventh Circuit based its conclusion on two facts: (1) the merger increased Hospital Corporation's Chattanooga market share from 14% to 26% in a market where the four largest hospitals controlled 90% of the market; and (2) the pre-merger market share for the four largest hospitals was 79%. *Id.* at 1384. In addition, the court relied on the fact that the acquisitions "reduced the number of competing hospitals in Chattanooga from 11 to 7." *Id.* at 1389.

²⁹ *Hospital Corp.*, 807 F.2d at 1388; see *United States v. Rockford Memorial Corp.*, 898 F.2d 1278 (7th Cir. 1989), *cert. denied*, 498 U.S. 920 (1990). *Rockford* involved an action brought by the United States to enjoin the merger of the two largest nonprofit hospitals in Rockford, Illinois, a city of 140,000 people. *Id.* at 1280. Rockford had three large acute-care hospitals: Rockford Memorial, SwedishAmerican Hospital, and St. Anthony Medical Center. *United States v. Rockford Memorial Corp.*, 717 F. Supp. 1251, 1292 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir.), *cert. denied*, 498 U.S. 920 (1990). In 1987, SwedishAmerican and Rockford Memorial proposed a merger which was to take place in 1988. *Id.* at 1252. After the United States commenced an action in the Northern District of Illinois to enjoin the merger, Rockford and SwedishAmerican agreed to refrain from further merger activity until after the

The contrary view, however, was expressed by the United States District Court for the Western District of Virginia in *United States v. Carilion Health Systems*.³⁰ In *Carilion*, the United States challenged the merger of two nonprofit hospitals in Roanoke, Virginia.³¹ The court defined the relevant product market more broadly than did the Seventh and Eleventh Circuits by including outpatient facilities that compete with hospitals providing outpatient services in addition to more traditional inpatient services.³²

The weight of authority supports the narrower product market definition (limited to inpatient acute-care facilities) that was imposed by the Seventh and Eleventh Circuits.³³ Moreover, commentators suggest that this narrow definition is more consonant with the policy of the enforcement agencies.³⁴ Most importantly, however, the FTC appears to have adopted

resolution of the litigation. *Id.* The court concluded that the relevant product market was inpatient services provided by acute-care hospitals. *Rockford*, 898 F.2d at 1284. In response to Rockford Memorial's contention that the product market definition should include outpatient services because such services are increasingly provided by acute-care hospitals, the Seventh Circuit concluded that if a monopoly exists for inpatient acute-care services, it is irrelevant that there is competition for other types of care. *Id.*

³⁰ 707 F. Supp. 840 (W.D. Va.), *aff'd*, 892 F.2d 1042 (4th Cir. 1989).

³¹ *Carilion*, 707 F. Supp. at 841. Defendant Carilion Health Systems was a nonstock, nonprofit holding company that owned Roanoke Memorial Hospital. *Id.* at 842. Also operating in the area were defendant Community Hospital of Roanoke Valley and Lewis Gale Hospital owned by Hospital Corporation of America. *Id.* The United States challenged the merger between Roanoke Memorial and Community Hospital. *Id.* at 841-42. Each of the three hospitals in the area provided significant outpatient care and varying degrees of inpatient acute care. *Id.* at 843.

³² *Carilion*, 707 F. Supp. at 847. The court concluded that:

Based on the finding above that providers of outpatient services compete with providers of inpatient services for the same patients in a significant number of cases, the court concludes that the relevant service market for this case includes not only other inpatient hospitals but also various outpatient clinics that treat medical problems for which patients might otherwise have sought treatment in an inpatient hospital setting.

Id. But in determining that the merger did not restrain competition, the court focused on the fact that the major competitor in the area was expected to put substantial pressure on the merged hospitals as the number of patients in the market who were hospitalized continued to decline. *Id.* at 848.

³³ See *FTC v. University Health, Inc.*, 938 F.2d 1206, 1206 (11th Cir. 1991); *Rockford*, 898 F.2d at 1284; *Hospital Corp.*, 807 F.2d at 1388; *In re Adventist Health Sys.*, No. 9234, slip op. at 3 (FTC Apr. 1, 1994). But see *Carilion*, 707 F. Supp. at 847 (defining relevant product market to include services from outpatient facilities with which inpatient acute-care hospitals compete).

³⁴ See, e.g., Feinstein, *supra* note 8, at 9 (citing *Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962)). Feinstein concluded that:

[R]elevant market is a function not of the goods and services the merging entities choose to provide, but of the goods and services available to serve reasonably similar consumer needs. . . . [B]y acknowledging the importance of identifiable subgroups of the provider's customers, the *Rockford* court's approach, like that of the Guidelines, leaves room for the analysis to focus on particular, highly specialized services not

this narrow product market definition.³⁵

2. The Relevant Geographic Market

The relevant geographic market is defined as the area surrounding the merged firms which is no larger than sufficient for the monopolist to find price increases profitable given consumer tendency to seek lower price suppliers when possible.³⁶ In the context of hospital mergers, the relevant geographic market can be determined using the Elzinga-Hogarty test.³⁷ This test produces an appropriate geographic market by measuring both the

generally available from other similarly situated entities.

Id.

³⁵ See *In re American Medical Int'l, Inc.*, 104 F.T.C. 1, 220-21 (1984) (employing narrow definition and requiring American Medical to divest hospital in California); see also *In re Hospital Corp. of Am.*, 106 F.T.C. 361, 466 (1985) (requiring divestiture of two hospitals in Tennessee). In *In re Hospital Corp.*, the issue of defining the relevant product market was not directly before the Commission. The Commission stated, however, that:

In any case, it is clear from the evidence that the core and vast majority of an acute care hospital's business is acute inpatient care. Certainly, it is clear that anticompetitive behavior by hospital firms could significantly lessen competition for hospital inpatients that could not be defeated by competition from non-hospital outpatient providers. Our analysis will hence proceed with primary reference to the cluster of services provided to inpatients.

Id. (citations omitted). For subsequent disposition of this case, see *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987).

³⁶ Merger Guidelines, *supra* note 11, at 41,552. In a market where there is no price discrimination, if the monopolist's price increase in a location would result in reduced sales, then the geographic market should be enlarged to include the "next-best substitute for production at the merging firm's location." *Id.* at 41,556. In determining the extent of a geographic market, the Merger Guidelines consider:

- (1) evidence that buyers have shifted or have considered shifting to relative changes in price or other competitive variables;
- (2) evidence that sellers base business decisions on the prospect of buyer substitution between geographic locations in response to relative changes in price or other competitive variables;
- (3) the influence of downstream competition faced by buyers in their output markets; and
- (4) the timing and cost of switching suppliers.

Id. If the monopolist is able to target buyers in the geographic market that are less willing to switch suppliers, and to raise prices only for those buyers, then appropriate additional geographic locations should be considered to account for buyers who are not the target of price discrimination. *Id.*; see also *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 359 (1963) (determining that geographic market is "area of effective competition . . . in which the seller operates, and to which the purchaser can practicably turn for supplies") (emphasis omitted) (quoting *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 327 (1961)).

³⁷ See Kenneth G. Elzinga & Thomas F. Hogarty, *The Problem of Geographic Market Delineation Revisited: The Case of Coal*, 23 ANTITRUST BULL. 1 (1987); Kenneth G. Elzinga & Thomas F. Hogarty, *The Problem of Geographic Market Delineation in Antimerger Suits*, 18 ANTITRUST BULL. 45 (1973).

percentage of patients who live in a given area and remain there for inpatient hospital services, and the percentage of patients living in the area who leave for inpatient hospital services.³⁸ Generally, the relevant geographic market in a hospital merger is defined as the area in which seventy-five to ninety percent of residents seek hospitalization and in which the same percentage of patients discharged from hospitals in the area reside.³⁹

In *United States v. Rockford Memorial Corp.*,⁴⁰ the Seventh Circuit employed the "clearly erroneous" standard to choose between two imperfect geographic market definitions.⁴¹ The defendant hospital offered a broad market definition which included the ten counties surrounding Rockford in northern Illinois and southern Wisconsin.⁴² The district court defined the geographic market as only the county in which Rockford is located and portions of several other counties;⁴³ eighty-seven percent of

³⁸ See, e.g., *United States v. Rockford Memorial Corp.*, 717 F. Supp. 1251, 1261-78 (N.D. Ill. 1989) (providing detailed analysis regarding use of Elzinga-Hogarty test), *aff'd*, 898 F.2d 1278 (7th Cir.), *cert. denied*, 498 U.S. 920 (1990). In *Rockford*, the court found the Elzinga-Hogarty test "a useful tool for eliminating certain geographic areas from consideration as relevant markets." *Id.* at 1271; see also *In re Adventist Health Sys.*, No. 9234, slip. op. at 6 (FTC Apr. 1, 1994) (finding that "historical or current patterns of patient flows are valuable sources of information in analyzing the question whether a hypothetical monopolist in a geographic area could exercise power"). The Commission also determined, however, that "other evidence is equally relevant." *Id.*; see Feinstein, *supra* note 8, at 11 (noting that "[i]n hospital merger cases, the identification of the geographic market begins with patient origin data for hospitals in the relevant firms' service area and those just outside the service area").

But see *Hospital Corp.*, 106 F.T.C. at 472 (stating that "static" Elzinga-Hogarty analysis was "incomplete"). Only after concluding that it would be "difficult" to find an appropriate market did the court accept the proposed market, for lack of a better alternative. *Id.*; see also *United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1285 (7th Cir. 1989) (characterizing district court's market definition as "imperfect" but adopting it nonetheless as "less imperfect" alternative under "clearly erroneous" standard of review), *cert. denied*, 498 U.S. 920 (1990).

³⁹ Feinstein, *supra* note 8, at 11; see *Rockford*, 717 F. Supp. at 1271 ("According to economic literature . . . figures equal to, or greater than, 90% represent[] a 'strong market' while a 75% figure represents a 'weak' market."). The *Rockford* Court, however, stated that this guideline "is of minimal utility since it suggests little more than that as the percentages increase, your confidence in your market should also increase." *Id.* at 1272.

⁴⁰ 898 F.2d 1278 (7th Cir. 1986), *cert. denied*, 498 U.S. 920 (1990).

⁴¹ *Id.* at 1285.

⁴² *Id.* at 1284.

⁴³ *Id.* The defendants employed the Elzinga-Hogarty test to define the relevant geographic market. *Rockford*, 717 F. Supp. at 1266; see *supra* notes 37-39 and accompanying text (discussing Elzinga-Hogarty test). The court concluded that "if adding certain areas or competitors to the market does not appreciably increase at least one of [the Elzinga-Hogarty factors], without decreasing the other, then that area should probably not be included in the market." *Rockford*, 717 F. Supp. at 1272. Because the defendants' geographic market definition failed to meet this standard, the court determined that the defendants' market definition was drawn too broadly. *Id.* at 1277; see also *Rockford*, 898 F.2d at 1284 (affirming district court

the defendants' patients resided in this area.⁴⁴ The Seventh Circuit acknowledged that the district court could have defined the geographic market more aptly by including an additional hospital in Beloit, but concluded that this shortcoming did not significantly alter market concentration figures.⁴⁵

The FTC employed similar patient flow analysis to define the relevant geographic market in *In re Hospital Corp. of America*⁴⁶ and *In re American Medical International, Inc.*⁴⁷ In *Hospital Corp.*, the Commission concluded that patient flow analysis is important but static and must be supplemented by analysis which considers the market effects of changes in price and output.⁴⁸ In *In re American Medical International, Inc.*, the Commission determined that American Medical's patient flow data prepared for litigation was clearly less probative than Medicare and Medi-

definition of relevant geographic market).

⁴⁴ *Rockford*, 898 F.2d at 1284.

⁴⁵ The Seventh Circuit reasoned:

It is always possible to take pot shots at a market definition (we have just taken one), and the defendants do so with vigor and panache. Their own proposal, however, is ridiculous—a ten-county area in which it is assumed (without any evidence and contrary to common sense) that Rockford residents, or third-party payors, will be searching out small, obscure hospitals in remote rural areas if the prices charged by the hospitals in Rockford rise above competitive levels.

Id. at 1285.

⁴⁶ 106 F.T.C. 361 (1985).

⁴⁷ 104 F.T.C. 1 (1984). In *In re Adventist Health Sys.*, No. 9234, slip op. at 3 (FTC Apr. 1, 1994), the FTC also used patient flow analysis in dismissing a complaint challenging the merger of a 43-bed hospital with a 51-bed hospital in Ukiah, California. *Id.* at 2. At the time of the merger in 1988, there were three hospitals operating in Ukiah: Ukiah Adventist Hospital (the 43-bed facility), Ukiah General Hospital (the 51-bed facility), and Mendocino Community Hospital (a 56-bed facility). *Id.* As a result of the merger, Ukiah Valley Medical Center was created, which operated as a 94-bed hospital at the two physically separate locations. *Id.* The Commission held that the government failed to demonstrate a sufficiently narrow geographic market to support its allegation that the merger would create adverse competitive effects. *Id.* at 9. The Commission reasoned that no evidence was offered to show that patients would not leave the geographic market if the merging hospitals raised prices. *Adventist Health*, No. 9234, slip op. at 9. Moreover, the Commission pointed out that the patient flow data did not support the government's geographic market definition because the data demonstrated that only 74.57% of residents did not seek hospital care outside the area. *Id.* at 7. The Commission also pointed out that the merging hospitals expressed a desire in their business strategy plan to recover patients from outside Ukiah through competition. *Id.* at 9. The Commission concluded that, assuming that such patient recovery through competition was possible, loss of patients to hospitals outside Ukiah was the likely result of anticompetitive conduct. *Id.* This premise led the Commission to include in its definition of the relevant geographic market the hospitals outside Ukiah that could compete for patients residing in Ukiah. *Id.*

⁴⁸ *Hospital Corp.*, 106 F.T.C. at 472. On the basis of this type of analysis, the Commission concluded that the relevant geographic market was the Chattanooga urban area. *Id.*

Cal data to the contrary.⁴⁹ In each of these opinions, however, the FTC noted that the relevant geographic market for hospital mergers is determined in large part by physician-admitting practices.⁵⁰ This is true because hospitals compete for physicians⁵¹ and because physicians play a primary role in determining where their patients are admitted.⁵²

3. Market Concentration Analysis

After defining the relevant product and geographic markets, the firms participating in the market and their market shares must be identified to determine whether the merger enhances market concentration to the extent of violating Section Seven of the Clayton Act.⁵³ Market concentration is often measured using the Herfindahl-Hirschman Index ("HHI"), which is calculated by determining the sum of the squares of the market shares for each firm in the relevant market.⁵⁴ The higher the HHI, the greater the

⁴⁹ *American Medical*, 104 F.T.C. at 196. The Commission pointed out that American Medical failed to address several of the administrative findings that it had initially challenged before the Commission. *Id.* In particular, the Commission noted that American Medical failed to dispute the geographic barriers, such as patient convenience, limited mobility, and location of admitting physicians, all of which called for a narrow definition of the geographic market. *Id.*

⁵⁰ See *Hospital Corp.*, 106 F.T.C. at 467; *American Medical*, 104 F.T.C. at 197; see also Mark J. Horoshak, *Antitrust and Health: Policy and Enforcement*, in HEALTH CARE LAW 1993, at 6 (PLI Com. L. & Practice Course Handbook Series No. A4-4428, 1993) ("Geographic market is determined by looking at various factors, including physician admitting practice . . .").

⁵¹ *American Medical*, 104 F.T.C. at 197 (noting that "[h]ospitals engage in very rigorous competition for their physicians").

⁵² *Id.* ("[I]t is the physician who is responsible for admitting patients to hospitals, and hospitals compete for physicians in order to increase admissions."). Thus, "physician preference, rather than patient choice, decides what hospital will be utilized." *Hospital Corp.*, 106 F.T.C. at 467; see also, Horoshak, *supra* note 50, at 4 (discussing physician referral power). But see Feinstein, *supra* note 8, at 23 (discussing "Stark Bill" which prohibits physicians from making referrals for any services in which they have any financial interest).

⁵³ See Merger Guidelines, *supra* note 11, at 41,557 ("Market concentration is a function of the number of firms in a market and their respective market shares."). Market shares can be expressed in dollar amounts or physical terms by measuring sales, shipments, or production. *Id.* When measurements are expressed in physical terms, capacity and reserves can also be used as indicators. *Id.* Concentration levels are calculated by applying the market share data to determine the pre-merger and post-merger concentration levels in the relevant market. *Id.* at 41,558.

⁵⁴ *Id.* at 41,557-58; see *FTC v. University Health, Inc.*, 938 F.2d 1206, 1211 n.12 (11th Cir. 1991) ("The most prominent method of measuring market concentration is the Herfindahl-Hirschmann Index (HHI)."); *United States v. Rockford Memorial Corp.*, 717 F. Supp. 1251, 1279 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir.), *cert. denied*, 498 U.S. 920 (1990). In *Rockford*, the United States District Court for the Northern District of Illinois adopted the HHI standard for measuring market concentration when it stated:

The HHI attempts to quantify a market's concentration by summing the squares of the individual market shares of all the firms in the market. This formula reflects the distribution of market shares between firms and gives proportionately greater weight to the market shares of the larger firms, which likely accords with their relative

concentration of the relevant market.⁵⁵

Both *University Health* and *Rockford* provide examples of courts using HHI figures to evaluate the competitive impact of hospital mergers. In *University Health*, the Eleventh Circuit vacated the district court's denial of the FTC's application for a preliminary injunction to prevent a hospital merger in a small market.⁵⁶ This disposition was in part based on the court's finding that the proposed merger would increase the HHI by 630, raising the index to approximately 3200.⁵⁷ In *Rockford*, the Northern District of Illinois calculated market concentration by examining the number of hospital beds, inpatient admissions, and inpatient days in the market.⁵⁸ Each of these bases indicated that the merger took place in an already highly concentrated market and generated an increase in the HHI of between 2000 and 3000.⁵⁹ The court granted a permanent injunction against the merger because it would have resulted in one hospital

importance in any anti-competitive interaction.

Id.; see also Feinstein, *supra* note 8, at 13 ("HHI figures relevant to merger analysis are (a) post-merger HHI for the relevant market, and (b) change in concentration evidenced by the difference between the post-merger HHI and the premerger HHI."); cf. *University Health*, 938 F.2d at 1211 n.12 (discussing four-firm concentration ratio, another method used to evaluate market concentration).

⁵⁵ See Merger Guidelines, *supra* note 11, at 41,558. An HHI of 10,000 indicates a perfect monopoly. *Id.* When the post-merger market HHI is below 1000, the market is considered unconcentrated and the merger is considered unlikely to cause adverse competitive effects. *Id.* In such cases there will ordinarily be no challenge to the merger. *Id.* When the post-merger market HHI is between 1000 and 1800, the market is considered moderately concentrated. *Id.* In such a market, if the HHI increases by less than 100, then the merger is also unlikely to have adverse competitive effects and ordinarily will not be challenged. Merger Guidelines, *supra* note 11, at 41,558. If the HHI increases by more than 100, however, then the merger raises significant antitrust concerns. *Id.* When the post-merger market HHI is greater than 1800, the market is considered highly concentrated. *Id.* In such a market, if the HHI increases by less than 50, it does not raise competitive concerns. *Id.* If, however, the HHI increases by more than 50, then the merger raises significant antitrust concerns. *Id.* See generally Gloma J. Bazzoli et al., *Federal Antitrust Merger Enforcement Standards: A Good Fit for the Hospital Industry*, 20 J. HEALTH POL. POL'Y & L. 137 (1995) (discussing application of HHI in detail).

⁵⁶ 938 F.2d at 1226. The court reasoned that a decision not to issue the injunction would frustrate the FTC's ability to safeguard competition and protect the public from anticompetitive behavior. *Id.* at 1225.

⁵⁷ *Id.* at 1211 n.12. The court specifically stated that "any merger that increases a market's HHI by over 100, to a post-merger level over 1000, raises antitrust concerns." *Id.* The premise behind these concerns is that a concentrated market will yield a higher HHI and an unconcentrated market will yield a lower number. See *Rockford*, 717 F. Supp. at 1279.

⁵⁸ *Rockford*, 717 F. Supp. at 1279-80. The court explained that it did not matter which of these three bases was used to calculate the HHI, since they all resulted in similar figures. *Id.* at 1280.

⁵⁹ *Id.* The court also noted that the concentration of the relevant market nearly doubled as a result of the merger. *Id.*; cf. *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 365 (1963) (labelling increase of only 33% in concentration as "significant").

controlling seventy percent of the market.⁶⁰

B. *Adverse Competitive Impact of Hospital Mergers*

Market share and concentration data are merely the beginning of an analysis of the competitive impact of horizontal mergers.⁶¹ Given a post-merger HHI which indicates potential adverse competitive impact in a moderately or highly concentrated market, the exact effect of the merger on the relevant market must be determined.⁶² Mergers may diminish competition by enabling firms in the relevant market to engage in coordinated interaction that harms consumers.⁶³ Alternatively, mergers may diminish competition without enhancing potential coordination because merging firms may find it profitable to elevate prices after the merger and reduce output without coordination.⁶⁴ The FTC and the DOJ will challenge mergers that increase the likelihood of this type of price and output control.⁶⁵

A merger is unlikely to create anticompetitive market power if entry into the market is sufficiently easy so that market participants could not profitably maintain prices above pre-merger levels.⁶⁶ Entry is easy in this

⁶⁰ *Rockford*, 717 F. Supp. at 1292. The court found that it was "simply impossible to ignore the language in [*Philadelphia Nat'l Bank*] that a 'merger which produces a firm controlling an undue percentage share of the relevant market . . . is so inherently likely to lessen competition substantially that it must be enjoined . . .'" *Id.* at 1291 (citation omitted).

⁶¹ See *Hospital Corp. of Am. v. FTC*, 807 F.2d 1381, 1386 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987). In this case the Seventh Circuit stated:

[T]he ultimate issue is whether the challenged acquisition is likely to facilitate collusion. In this perspective the acquisition of a competitor has no economic significance in itself; the worry is that it may enable the acquiring firm to cooperate (or cooperate better) with other leading competitors on reducing or limiting output, thereby pushing up the market price.

Id.: see Merger Guidelines, *supra* note 11, at 41,558 ("The smaller the percentage of total supply that a firm controls, the more severely it must restrict its own output in order to produce a given price increase, and the less likely it is that an output restriction will be profitable.").

⁶² In addition to market share and concentration ratios, the FTC will "assess the other market factors that pertain to competitive effects" before deciding whether to challenge a merger. Merger Guidelines, *supra* note 11, at 41,558. *But see Rockford*, 717 F. Supp. at 1291-92 (using only market share and concentration data to conclude that merger would result in firm controlling undue percentage share of relevant market).

⁶³ Merger Guidelines, *supra* note 11, at 41,558; see *Hospital Corp.*, 807 F.2d at 1386 (discussing concern that mergers will lead to cooperation with leading competitors in reducing or limiting output thereby driving up market price).

⁶⁴ See Merger Guidelines, *supra* note 11, at 41,560.

⁶⁵ See, e.g., *Hospital Corp.*, 807 F.2d at 1386 (explaining that economic concept of competition requires FTC to challenge mergers that are likely to harm consumers).

⁶⁶ Merger Guidelines, *supra* note 11, at 41,561; see also Gregory Vistnes, *Hospital Mergers and Antitrust Enforcement*, 20 J. HEALTH POL. POL'Y L. 175, 187 (1995) ("If entry is likely,

context if it is timely, likely, and sufficient in magnitude, character, and scope to counteract the adverse effects of the merger.⁶⁷ State certificate-of-need laws restricting entry and expansion into hospital markets, however, make it unlikely that ease of entry will justify an otherwise anti-competitive hospital merger.⁶⁸ Such laws restrict entry into and expansion of hospital markets as a means of controlling the quality and price of hospital services.⁶⁹

Mergers that create efficiencies resulting in lower prices to consumers are likely to survive Section Seven scrutiny.⁷⁰ Efficiency claims,

then postmerger price increases may be reversed or hospitals may abstain from increasing price so as not to induce entry.”).

⁶⁷ Merger Guidelines, *supra* note 11, at 41,560; *see also* Vistnes, *supra* note 66, at 187 (stating that “such entry is generally very expensive, very slow, financially imprudent even if prices increase, and is often restricted by certificate of need laws”).

⁶⁸ Certain states require a certificate of need for the establishment of acute-care hospitals, expansion of bed capacity, significant capital outlays, and changes in services provided. *In re Hospital Corp. of Am.*, 106 F.T.C. 361, 489 (1985), *aff’d*, 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987).

⁶⁹ *See* *United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1285 (7th Cir.) (“Regulatory limitations on entry into the hospital industry increase the propensity to collude by preventing (or at least delaying and increasing the cost of) entry by new competitors to take advantage of an increase in prices.”), *cert. denied*, 498 U.S. 920 (1990); *Hospital Corp.*, 807 F.2d at 1387 (noting that Tennessee’s certificate-of-need law reduced ability of existing hospitals to expand output and reduced ability of new hospitals to enter market in ways that counter adverse competitive effects of merger).

In *North Carolina ex rel. Edmisten v. P.I.A. Asheville, Inc.*, 722 F.2d 59, 68 (4th Cir. 1983), *cert. denied*, 471 U.S. 1003 (1985), the Fourth Circuit held that a hospital merger approved under state certificate-of-need laws enacted pursuant to the National Health Planning and Resources Development Act of 1974, 42 U.S.C. § 300 (1994), was protected from enforcement agency challenge by an implied antitrust exemption. The court interpreted the Supreme Court’s holding in *National Gerimedical Hosp. & Gerontology Ctr. v. Blue Cross*, 452 U.S. 378 (1981), as allowing an antitrust exemption when a state regulatory review and approval process exists. *Id.* But *see Rockford*, 898 F.2d at 1285 (citing *National Gerimedical* for proposition that regulatory limitations on market entry do not create implied antitrust exemption); *see also infra* notes 73-74 and accompanying text (discussing state action immunity doctrine).

⁷⁰ Merger Guidelines, *supra* note 11, at 41,562. Mergers are attractive to both firms and society because of the efficiencies created by their resulting collaboration. *Id.* Antitrust law is designed to prohibit only those mergers which create efficiencies in ways that “present a significant danger to competition.” *Id.*; *see also* Policy Statements, *supra* note 8, at 20,774 (“Antitrust challenges to hospital mergers are relatively rare.”). The Department of Justice and the FTC have challenged only a handful of the hundreds of hospital mergers that have taken place since 1987. *Id.*

Commentators seem to agree that hospital mergers create economies of scale, both by eliminating duplicate services and overcapacity, and by enabling hospitals to provide a broader package of acute-care services. *See, e.g.*, Matthew, *supra* note 6, at 839-45 (discussing studies which show that as competing hospitals merge, overall industry costs decrease); McCarthy & Weinstein, *supra* note 3, at 7 (concluding that hospital mergers designed to gain market share and cost efficiencies represent important option for struggling hospitals).

however, will be rejected if the merging parties can achieve equivalent or comparable savings through means that threaten less competitive harm.⁷¹ Similarly, a merger is unlikely to enhance market power to the extent of violating Section Seven if imminent failure of one of the merging firms would cause the assets of that firm to exit the market if the merger did not occur.⁷²

C. Ownership Structure and Size of Merging Hospitals

The ownership structure of merging hospitals may influence their treatment under Section Seven. For instance, state-owned hospitals are exempt from antitrust scrutiny under the state action immunity doctrine.⁷³ When a state entity seeks antitrust immunity, it must demonstrate that: (1) it is a political subdivision of the state; (2) through statutes, the state generally authorizes the political subdivision to perform the challenged action; and (3) through statutes, the state has clearly articulated a state policy authorizing anticompetitive conduct.⁷⁴

⁷¹ Merger Guidelines, *supra* note 11, at 41,552; *see* FTC v. University Health, Inc., 938 F.2d 1206, 1223 (11th Cir. 1991) ("[A] defendant who seeks to overcome a presumption that a proposed acquisition would substantially lessen competition must demonstrate that the intended acquisition would result in significant economies and that these economies ultimately would benefit competition . . ."); *see also* *In re American Medical Int'l, Inc.*, 104 F.T.C. 1, 219 (1984) (rejecting efficiency claim because American Medical failed to demonstrate that substantial efficiencies could not be achieved within comparable period of time through combination which posed less threat of competitive harm).

⁷² Merger Guidelines, *supra* note 11, at 41,558; *see* *University Health*, 938 F.2d at 1221 (recognizing that financial weakness of acquired firm only precludes FTC challenge when weakness cannot be cured by competitive means and indicates that merger would be unlikely to have adverse competitive effects); Janet L. McDavid, *Antitrust Analysis of Hospital Mergers*, in HEALTH CARE REFORM AND ANTITRUST, 369 (PLI Com. L. & Practice Course Handbook Series No. 694, 1994) (stating that failing firm defense is "strictly construed by the antitrust agencies").

⁷³ *See* FTC v. Hospital Bd. of Directors, 38 F.3d 1184, 1187-88 (11th Cir. 1994) (discussing requirements for government entity to qualify for antitrust immunity); *Askew v. DCH Regional Health Care Auth.*, 995 F.2d 1033, 1037 (11th Cir.) (discussing two prong-test for distinguishing immunity from antitrust liability), *cert. denied*, 114 S. Ct. 603 (1993); *see also* Sarah S. Vance, *Immunity for State-Sanctioned Provider Collaboration After Ticor*, 62 ANTITRUST L.J. 409 (1994) (surveying state legislative attempts to create antitrust immunity for private providers in hospital industry).

⁷⁴ *Hospital Bd. of Directors*, 38 F.3d at 1187-88; *see also* *Askew*, 995 F.2d at 1037 ("[W]hen a local governmental entity seeks immunity from antitrust liability, it must show that it is a political subdivision of the state and that the challenged conduct is authorized under a 'clearly articulated and affirmatively expressed' policy of the state." (quoting *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 39 (1985))).

Similarly, when a state attempts to immunize private conduct from antitrust scrutiny it must (1) clearly articulate through legislation the affirmative policy of permitting anticompetitive conduct, and (2) actively supervise the private conduct that occurs pursuant to that policy. *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980). The

In *FTC v. Hospital Board of Directors*,⁷⁵ the Florida Legislature created a nonprofit publicly owned organization to establish and manage a public hospital for Lee County.⁷⁶ The Florida Legislature later extended the organization's power by allowing it to operate additional hospitals in the county.⁷⁷ When the organization sought to acquire a private hospital, the FTC challenged the proposed merger as a violation of Section Seven.⁷⁸ The Eleventh Circuit held that, because anticompetitive effects were foreseeable by the Florida Legislature when it allowed the organization to purchase other hospitals, the state action doctrine immunized the organization from federal antitrust laws.⁷⁹

Supreme Court has looked unfavorably upon the application of the state action immunity doctrine to private conduct. *See* *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621, 636 (1992). This disfavor manifested itself in the requirement that state supervision be exercised in practice and not merely provided for by statute. *Id.* The Eleventh Circuit in *Askew*, however, held that the active state supervision requirement does not apply to municipalities or political subdivisions because there is little danger that they will engage in anticompetitive conduct. *Askew*, 995 F.2d at 1037. For a comprehensive discussion of state legislative efforts to immunize private collaborative conduct in the hospital industry from antitrust scrutiny, see Vance, *supra* note 73, at 416-31.

⁷⁵ 38 F.3d 1184 (11th Cir. 1994).

⁷⁶ *Id.* at 1186. The organization was created in 1963, when there was only one hospital in Lee County. *Id.* at 1192. Pursuant to the legislation, the organization acquired the hospital, thereby creating a monopoly in the county. *Id.*

⁷⁷ *Id.*

⁷⁸ *Hospital Bd. of Directors*, 38 F.3d at 1192.

⁷⁹ *Id.* The Eleventh Circuit stated that "[t]he Supreme Court and this Circuit have rejected the concept that a clear articulation requires the state to state explicitly that it expects anticompetitive conduct to result from legislation. Instead, a clear articulation merely requires that anticompetitive conduct is the foreseeable result of the legislation." *Id.* at 1188 (citations omitted).

Prior to *Hospital Bd. of Directors*, the Eleventh Circuit dealt with the state action immunity doctrine in *Askew v. DCH Regional Health Care Auth.*, 995 F.2d 1033 (11th Cir.), *cert. denied*, 114 S. Ct. 603 (1993). In *Askew*, the Alabama Legislature enacted a law providing for the creation of public health care authorities with the power to acquire and operate public health care facilities. *Id.* at 1034. Aiming to provide new financing options for indigent and reduced care patients, the Alabama Legislature conferred broad powers upon health care authorities, including authorization "[t]o create, establish, acquire, operate or support subsidiaries and affiliates, either for profit or nonprofit, to assist such authority in fulfilling its purposes" *Id.* at 1035; ALA. CODE § 22-21-358(4) (1990); *see* ALA. CODE § 22-21-312 (1982). Private plaintiffs sued under federal antitrust law to enjoin a health care authority's acquisition of a privately owned acute-care hospital. *Askew*, 995 F.2d at 1035. The Eleventh Circuit held that the proposed acquisition was protected from federal antitrust challenge under the state action immunity doctrine. *Id.* at 1041. The Eleventh Circuit found that any health care authority incorporated under the Alabama Health Care Authorities Act was a political subdivision of the state. *Id.* at 1038-39. The Alabama Act authorized a health care authority "[t]o exercise all powers granted hereunder in such manner as it may determine to be consistent with the purposes of this article, notwithstanding that as a consequence of such exercise of such powers it engages in activities that may be deemed 'anti-competitive' within the contemplation of the antitrust laws of the state or of the United States" ALA. CODE § 22-21-318(a)(31) (1982). Because DCH was a political subdivision of the state acting consistently with its authorization and because the Alabama statute made specific

Nonprofit hospital corporations may also require special treatment under Section Seven. There is a split of authority regarding whether nonprofit hospitals fall under the FTC's jurisdiction to enjoin mergers under Section Seven when the merger is accomplished through asset acquisition.⁸⁰ While the contention that the FTC has jurisdiction to enjoin anti-competitive asset acquisitions by nonprofit hospitals seems to be the better reasoned approach, the issue is still unresolved.⁸¹

While the ownership structure of merging hospitals dictates their treatment under Section Seven, the size of the merging firms can also be important. Under the Hart-Scott-Rodino Antitrust Improvements Act of 1976,⁸² when either of the merging firms is engaged in commerce, and when either has assets or annual net sales of more than \$10,000,000 and the other has assets or annual net sales of more than \$100,000,000, the parties must file pre-merger notification with the FTC and abstain from

reference to the legislature's anticipation of anticompetitive conduct, the court concluded that the state action immunity doctrine protected the health care authority. *Askew*, 995 F.2d at 1039-41.

⁸⁰ Compare *FTC v. University Health, Inc.*, 938 F.2d 1206, 1209 (11th Cir. 1991) (holding that because nonprofit hospitals are not exempt from FTC Clayton Act jurisdiction under Section Eleven, nonprofit hospitals are subject to FTC jurisdiction for enforcement of Section Seven regarding asset acquisitions) and *United States v. Rockford Memorial Corp.*, 898 F.2d 1278, 1280 (7th Cir.) (reasoning in dictum that nonprofit merger is subject to Section Seven when understood to refer to Section Eleven of Clayton Act), *cert. denied*, 498 U.S. 920 (1990) with *United States v. Carilion Health Sys.*, 707 F. Supp. 840, 841 n.1 (W.D. Va.) (holding that FTC Section Seven jurisdiction over nonprofit hospitals is precluded by Federal Trade Commission Act), *aff'd*, 892 F.2d 1042 (4th Cir. 1989). In *University Health*, the Eleventh Circuit reasoned that because regulation of nonprofit hospitals is not expressly granted to another federal agency in Section Eleven, nonprofit hospital asset acquisitions fall under the FTC's Section Seven jurisdiction. *University Health*, 938 F.2d at 1214-15. The Seventh Circuit also promoted the granting of authority over nonprofit acquisition to the FTC under Sections Seven and Eleven, despite the court's inability to base its holding on the Clayton Act due to the government's failure to proffer the argument. *Rockford*, 898 F.2d at 1280. The Fourth Circuit, on the other hand, affirmed the reasoning of the United States District Court for the Western District of Virginia that the FTC does not have jurisdiction over nonprofit asset acquisitions because the Federal Trade Commission Act confers no such jurisdiction. *Carilion*, 707 F. Supp. at 841 n.1.

⁸¹ See, e.g., Mudge & Gibofsky, *supra* note 15, at 377 (explaining that *Rockford* appears more valuable because it provides more complete analysis of issue). The Seventh and Eleventh Circuits' focus on the legislative purpose of Sections Seven and Eleven of the Clayton Act seems to be the better reasoned approach when compared to the cursory treatment of the issue by the Western District of Virginia. Compare *University Health*, 938 F.2d at 1213-15 and *Rockford*, 898 F.2d at 1280-81 with *Carilion*, 707 F. Supp. at 841 n.1. That the Fourth Circuit affirmed *Carilion* with an unpublished opinion, see *United States v. Carilion Health Sys.*, 892 F.2d 1042 (4th Cir. 1989), further undermines the precedential value of the district court's rational. See Mudge & Gibofsky, *supra* note 15, at 377.

⁸² Pub. L. No. 94-435, § 201, 90 Stat. 1390 (1976) (codified as amended at 15 U.S.C. § 18a (1994)).

further merger activity until the lapse of a prescribed waiting period.⁸³ In addition, where merging hospitals have over the previous three years an average of fewer than 100 licensed beds and an average daily in-patient census of fewer than 40 patients, the hospitals fall into a "safety zone" in which the FTC and the DOJ will not challenge the merger.⁸⁴ This safety zone applies absent extraordinary circumstances, but does not apply to hospitals less than five years old.⁸⁵

II. PUBLIC POLICY AND ANTITRUST LAW IN THE HEALTH CARE INDUSTRY

Given the overcapacity in the hospital industry that has developed over

⁸³ Section 18a(a) provides:

Except as exempted pursuant to subsection (c) . . . , no person shall acquire, directly or indirectly, any voting securities or assets of any other person, unless both persons (or in the case of a tender offer, the acquiring person) file notification pursuant to rules under subsection (d)(1) . . . and the waiting period described in subsection (b)(1) has expired, if—

(1) the acquiring person, or the person whose voting securities or assets are being acquired, is engaged in commerce or in any activity affecting commerce;

(2)(A) any voting securities or assets of a person engaged in manufacturing which has annual net sales or total assets of \$10,000,000 or more are being acquired by any person which has total assets or annual net sales of \$100,000,000 or more;

(B) any voting securities or assets of a person not engaged in manufacturing which has total assets of \$10,000,000 or more are being acquired by any person which has total assets or annual net sales of \$100,000,000 or more; or

(C) any voting securities or assets of a person with annual net sales or total assets of \$100,000,000 or more are being acquired by any person with total assets or annual net sales of \$10,000,000 or more; and

(3) as a result of such acquisition, the acquiring person would hold—

(A) 15 per centum or more of the voting securities or assets of the acquired person, or

(B) an aggregate total amount of the voting securities and assets of the acquired person in excess of \$15,000,000.

In the case of a tender offer, the person whose voting securities are sought to be acquired by a person required to file notification under this subsection shall file notification pursuant to rules under subsection (d). . . .

15 U.S.C. § 18a(a) (1994).

Subsection (c) of Section 18(a) lists exempt transactions including acquisitions of goods and realty in the ordinary course of business, acquisitions of non-voting securities, and transfers from federal and state agencies. *Id.* § 18a(c) (1994).

⁸⁴ Policy Statements, *supra* note 8, at 20,774. The agencies recognize that such hospitals are likely to be the only ones in the relevant market and compete little with other area hospitals. Thus, a merger is not likely to substantially reduce competition. *Id.* Also, many such mergers involve rural hospitals with collaboration being their only opportunity to realize some of the cost-saving efficiencies of larger hospitals.

⁸⁵ *Id.*

the last 30 years,⁸⁶ the concurrent inflation of health care costs,⁸⁷ and competition from managed care organizations,⁸⁸ members of the hospital industry are seeking to cut cost and enhance their competitive positions by consolidating.⁸⁹ This trend has generated controversy concerning the antitrust treatment of hospital mergers.⁹⁰

A. *Hospital Industry Criticism of Current Antitrust Law*

Members of the hospital industry assert that federal antitrust laws present an obstacle to the necessary restructuring of the health care industry.⁹¹ With an industry shift toward outpatient care,⁹² hospitals are confronted with significant overcapacity in facilities that are costly to maintain.⁹³ The American Hospital Association ("AHA") contends that collaboration provides an efficient means of reducing overcapacity and the cost of needlessly duplicative services.⁹⁴ The AHA further argues that the

⁸⁶ See Susman & Martland, *supra* note 6, at 3 (identifying overcapacity as motivation for hospital collaboration); Bernstein, *supra* note 6, at 78 (discussing low occupancy levels as factor driving hospitals to collaborate).

⁸⁷ See Entin et al., *supra* note 2, at 108-09 (noting that health care costs have "continued to rise faster than the rate of inflation over the last three decades"); see also *supra* note 7 (discussing fixed-price government reimbursement under prospective payment system instituted under 1983 Amendments to Social Security Act).

⁸⁸ See Bernstein, *supra* note 6, at 77 (identifying competition from managed-care providers as motivation for hospital collaboration).

⁸⁹ See *supra* notes 3-7 and accompanying text (discussing current trend toward hospital collaboration).

⁹⁰ See Matthew, *supra* note 6, at 814-15 (arguing that hospital industry deserves special antitrust treatment because it performs "atypically under competitive market conditions"); Entin et al., *supra* note 2, at 110 ("The antitrust laws, as currently enforced, are inappropriately inhibiting the rational restructuring of the health care system through collaborative efforts."); Susman & Martland, *supra* note 6, at 3 ("The American Hospital Association and American Medical Association have argued forcefully that antitrust enforcement is counter-productive and chills potentially cost-saving consolidations. Both have called for special antitrust exemptions for health care mergers and joint activities."). But see Meyer & Rule, *supra* note 8, at 171 (arguing that current federal antitrust law is sufficiently flexible to allow health care collaboration designed to reduce costs and increase efficiency, and that immunity from antitrust law is unnecessary to attain these objectives).

⁹¹ See Susman & Martland, *supra* note 6, at 3 (presenting medical association arguments against antitrust laws).

⁹² See Bernstein, *supra* note 6, at 77-78 ("[H]ospitals are feeling the pressure of lower occupancy levels and are hurrying to develop or convert existing structures to outpatient facilities.").

⁹³ See *supra* notes 6, 86, 87 and accompanying text (discussing overcapacity and rising health care costs).

⁹⁴ AMERICAN HOSPITAL ASS'N, NATIONAL HEALTH CARE REFORM: REFINING AND ADVANCING AND VISION 11 (1992) [hereinafter AMERICAN HOSPITALS ASS'N]; see Entin et al., *supra* note 2, at 110; Susman & Martland, *supra* note 6, at 3; see also Matthew, *supra* note 6,

reduction of overcapacity and duplicate costs is unlikely through the normal market incentives that antitrust law strives to maintain⁹⁵ because the third party payor system desensitizes the hospital industry to market incentives,⁹⁶ and because hospitals are forced to invest in underutilized technology to prevent physicians from choosing to work at better equipped facilities.⁹⁷ These arguments have lead many in the hospital industry to conclude that antitrust law should be relaxed in the health care industry to encourage this type of collaboration,⁹⁸ or in any event, be made more predictable to reduce the prohibitive costs associated with FTC investigations of hospital mergers.⁹⁹

B. *The Response to Industry Criticism*

The response to the hospital industry's criticism of antitrust law centers around the argument that promoting competition is the most effective method of protecting health care consumers.¹⁰⁰ Federal enforce-

at 815 (analyzing hospital mergers under "natural monopoly theory").

⁹⁵ AMERICAN HOSPITALS ASS'N, *supra* note 94, at 11; see Entin et al., *supra* note 2, at 109-10 (arguing that market incentives promoted by current antitrust law are insufficient to foster necessary restructuring of hospital industry); see also 15 U.S.C. § 1 (1994) (prohibiting contract, combination, or conspiracy in restraint of trade); 15 U.S.C. § 18 (1994) (prohibiting acquisitions that reduce competition or tend to create monopoly).

⁹⁶ See Entin et al., *supra* note 2, at 123 ("In hospital markets, most individual consumers, including those who are beneficiaries of public programs, are insulated from market prices by third-party insurance."); Matthew, *supra* note 6, at 848 ("Hospitals have largely been relieved from price competition because the consumer of health services—the patient—has not been the direct purchaser of health services and therefore did not bear the economic cost of his or her health care.").

⁹⁷ See Entin et al., *supra* note 2, at 124 (stating that hospitals compete for physicians by offering state-of-the art equipment); Matthew, *supra* note 6, at 848 ("Hospitals purchase bigger, fancier technologies in order to attract and retain the most sophisticated physicians.").

⁹⁸ See Entin et al., *supra* note 2, at 137 (arguing that antitrust law should be changed so as not to frustrate "efforts to promote beneficial hospital collaboration"); Matthew, *supra* note 6, at 871 (concluding that antitrust law should be reformed to promote economies of scale generated by hospital mergers).

⁹⁹ See Entin et al., *supra* note 2, at 137 (arguing that federal antitrust policy sends mixed signals to hospital industry concerning what collaborative conduct violates antitrust law); Mudge & Gibofsky, *supra* note 15, at 384 (concluding that decisional law should more clearly articulate "standards by which hospital mergers will be judged"); Susman & Martland, *supra* note 6, at 3 ("[I]f the federal enforcement agencies wanted to eliminate uncertainty about what conduct would or would not raise antitrust concern, they have failed.").

¹⁰⁰ See, e.g., Meyer & Rule, *supra* note 8, at 171 ("[S]ound antitrust policy, and the system of free-enterprise competition it reflects, provide the most reliable means to ensure the emergence of the sort of marketplace innovations, including those involving collaboration, that can minimize health care costs."). In her statement before the Senate Finance Committee, Mary Lou Steptoe, Acting Director of the FTC Bureau of Competition, stated:

At their core, the proposed exemptions for physicians and hospitals may be based on

ment agencies argue that current antitrust policy is sufficiently flexible to accommodate efficient collaboration in the hospital industry.¹⁰¹ Furthermore, because relatively few hospital mergers have been challenged in proportion to the enormous number of mergers which have recently occurred,¹⁰² the agencies claim that antitrust impediments to such collaboration are more perceived than real.¹⁰³ The enforcement agencies have arguably advanced competition in the health care industry by tearing down professional ethics standards that once restricted competition and by eradicating conspiracies between providers to limit third party payor cost containment efforts.¹⁰⁴ Finally, it has been suggested that the benefit of a fact-intensive standard for judging adverse competitive effects outweighs the need for greater predictability in antitrust law's application to hospital mergers.¹⁰⁵

questionable arguments about the nature of competition in health care markets and how antitrust law applies to physicians and hospitals. One argument is that due to market imperfections, competition in health care does not work to contain costs and ensure quality. The other argument is that antitrust law is not flexible enough to deal with markets, such as many health care markets, that may not resemble perfect competition. In our view, however, the record of antitrust enforcement in the health care field shows that competition is important to containing costs and ensuring quality, and that antitrust enforcement is flexible enough to prevent harmful conduct without interfering with efficient joint conduct that benefits consumers.

Antitrust Law Enforcement and Health Care Markets: Hearings Before the Senate Finance Committee, 103d Cong., 2d Sess. 5 (1994) [hereinafter *Steptoe Finance Committee Statement*] (statement of Mary Lou Steptoe, Acting Director, FTC Bureau of Competition).

¹⁰¹ *Id.*; Feinstein, *supra* note 8, at 20.

¹⁰² See Policy Statements, *supra* note 8, at 20,774 ("Antitrust challenges to hospital mergers are relatively rare. Of the hundreds of hospital mergers in the United States since 1987, the Agencies have challenged only a handful, and in several cases sought relief only as to part of the transaction."); see also HEALTH, EDUCATION, & HUMAN SERVICES DIVISION, GOVERNMENT ACCOUNTING OFFICE, NO. B-252783, HEALTH CARE-FEDERAL AND STATE ANTITRUST ACTIONS CONCERNING THE HEALTH CARE INDUSTRY 5 [hereinafter GAO REPORT] (stating that of 397 Hart-Scott-Rodino Act filings between 1981 and 1993, only 15 filings were challenged or withdrawn).

¹⁰³ See Meyer & Rule, *supra* note 8, at 174 ("[T]he impediments to legitimate cooperation by health care field participants, aimed at achieving the most efficient possible market outcomes, are more imagined than real."); see also Christine A. Varney, New Directions at the FTC: Efficiency Justifications in Hospital Mergers and Vertical Integration Concerns, Remarks Before the Healthcare Antitrust Forum, 1995 WL 255938, at *1 (F.T.C.) (May 2, 1995) (explaining that because of overcapacity and difficulty of entry in hospital markets, FTC will consider, in depth, efficiency claims of merging hospitals before challenging merger).

¹⁰⁴ See Feinstein, *supra* note 8, at 22-23.

¹⁰⁵ See *supra* part I.A. (discussing standards applied to relevant market definition and concentration data for hospital mergers); Meyer & Rule, *supra* note 8, at 197-200.

III. ANTITRUST LAW SHOULD NOT BE RELAXED IN THE HEALTH CARE INDUSTRY

Evidence seems to support the contention that antitrust protection is necessary in the hospital industry. An initial study has shown that merged hospitals typically do not pass on efficiency gains to consumers in the form of lower prices for health services.¹⁰⁶ Rather, these hospitals typically increase profits in direct relation to increases in market share, passing on such profits only to those consumers who participate in business managed care organizations or coalitions that enhance their bargaining positions.¹⁰⁷ If proven true over time, these statistics appear to undermine the argument against antitrust enforcement in the health care industry by highlighting the danger of collaboration in moderately or highly concentrated markets. This premise is reflected in the efficiency defense contemplated by the enforcement agencies which only applies when the economies generated by the merger are passed on to the consumer in the form of lower prices.¹⁰⁸

Moreover, it appears that current antitrust law is sufficiently flexible to allow pro-competitive hospital collaboration.¹⁰⁹ While proprietary hospitals continue to merge at a staggering rate,¹¹⁰ the FTC and the DOJ have challenged relatively few hospital mergers.¹¹¹ In addition, the FTC

¹⁰⁶ Jay Greene, *Merger Monopolies Research Shows Merging Hospitals May Be Promising Employers More Than They Can Deliver*, MOD. HEALTHCARE, Dec. 5, 1994, at 38 ("[O]n average, . . . 18 merged hospitals increased their prices a total of 9% two years after a merger, compared with a 1% price hike the year before the merger.")

¹⁰⁷ *Id.*

¹⁰⁸ Merger Guidelines, *supra* note 11, at 41,562 (recognizing efficiency defense may be difficult to demonstrate). It is submitted that, as a policy matter, efficiency should only preclude antitrust analysis when savings benefit consumers. To the extent such benefits are not realized, antitrust scrutiny appears necessary to determine if combination produces anticompetitive effects. See *Steptoe Finance Committee Statement*, *supra* note 100, at 5.

¹⁰⁹ See Meyer & Rule, *supra* note 8, at 171 ("[F]ederal antitrust laws, as presently written and sensibly enforced, provide a great deal of flexibility for private collaborative efforts aimed at achieving more efficient and less costly health care services."); *supra* notes 100, 101, and 103 and accompanying text. An example of this flexibility is the FTC practice of allowing a merger to go forward while requiring the acquiring firm to divest only the assets the acquisition of which raised competitive concerns. See Janet D. Steiger, Remarks Before the Antitrust Section of the American Bar Association, 1995 WL 155943, at *4 (F.T.C.) (Apr. 7, 1995) (describing example of such merger agreement in pharmaceutical industry); Mary Lou Steptoe, Current Issues in Health Care Antitrust: Boycotts, Mergers, and Provider Networks, Remarks Before the American Bar Association Section of Antitrust Law Spring Meeting, 1995 WL 150724, at *6 (F.T.C.) (Apr. 5, 1995) (stating Commission's objective is to distinguish "those elements of the transaction that would have a detrimental effect on competition from those elements that would not").

¹¹⁰ See *supra* notes 3-5 and accompanying text.

¹¹¹ See *supra* note 102 and accompanying text; *Steptoe Finance Committee Statement*, *supra* note 100, at 7.

and the DOJ have been less likely to challenge joint ventures for local sharing of expensive medical equipment when such ventures reduce cost to consumers.¹¹² Finally, both the FTC and the DOJ have expressed a willingness to render advisory opinions to firms which are contemplating merger activity, but which are uncertain about their status under antitrust law.¹¹³

CONCLUSION

The first step in antitrust analysis of hospital mergers is to define the relevant market in which the merger occurs. The relevant market is most aptly defined as including only inpatient acute-care hospital services in an area where 75 to 90 percent of the residents seek such acute care and where 75 to 90 percent of patients reside. Once the relevant market is identified, market concentration analysis is used to determine if the merger raises competitive concerns to the extent of violating Section Seven of the Clayton Act. There are several factors, however, which may preclude antitrust challenge even of mergers that otherwise raise competitive concerns: efficiencies created by the merger; prevention of failing hospitals from exiting the market; ease of entry into the market given state certificate-of-need laws; the size of the merging hospitals; and their ownership structures.

Indications that merged hospitals pass to consumers cost savings gained from enhanced market power only when forced to do so highlight the typical market incentives motivating hospital collaboration. Indeed, such evidence demonstrates the risks of relaxing antitrust policy in the health care industry. Moreover, given the infrequency with which the enforcement agencies challenge hospital mergers, their willingness to render pre-merger advice, and the existence of alternative forms of

¹¹² Policy Statements, *supra* note 8, at 20,775-79; see GAO REPORT, *supra* note 102, at 5 ("Neither DOJ nor FTC has ever challenged a hospital joint venture."); Meyer & Rule, *supra* note 8, at 192-94 ("[E]nforcers have long encouraged parties to consider joint ventures as a precompetitive alternative to outright mergers."); *Steptoe Finance Committee Statement*, *supra* note 100, at 8; Robert J. Enders, *An Introduction to Special Antitrust Issues in Health Care Provider Joint Ventures*, 61 ANTITRUST L.J. 805, 809 (1993) (finding that joint ventures between hospitals often arise as less risky antitrust alternative to complete merger or acquisition).

¹¹³ Policy Statements, *supra* note 8, at 20,774 (stating that hospitals considering mergers desiring certainty regarding antitrust laws may take advantage of DOJ's review program or FTC's advisory opinion); see Gail Kursh, Recent Activities of the Antitrust Division in the Health Care Field, Address Before the American Bar Association, 1995 WL 217865, at *2 (D.O.J.) (Apr. 5, 1995) ("The expedited business review program [provided for in the 1993 Joint Policy Statement] has been very successful. During the past two years, the Division issued 18 health care business review letters, and we have almost an equal number currently under consideration.").

collaboration which pose less of a threat to competition, current antitrust, law as enforced by the DOJ and the FTC, is flexible enough to allow pro-competitive combination in the hospital industry.

William M. Stelwagon

